LOS ANGELES COUNTY - DEPARTMENT OF HEALTH SERVICES
ALCOHOL & DRUG PROGRAM ADMINISTRATION
FEE FOR SERVICE (RESIDENTIAL AND NON-RESIDENTIAL)

PROPOSITION 36 USE ONLY

PROVIDER NAME:_____ CONTRACT NO.:_____
ADDRESS:_____ CLAIM PERIOD:_____
CITY:_____ZIP:_____ DATE PREPARED:_____
SERVICE CATEGORY:_____ PROVIDER NO.:_____
CONTACT PERSON: _____ PHONE: _____

SECTION V - PROVIDER SERVICE SUMMARY

	TCPX NUMBER	LAST NAME	FIRST NAME	ADMISSION DATE	DEPARTURE DATE	RESIDENT/ CLIENT DAYS	OUTPATIENT	
							INDIVIDUAL	GROUP
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